Halsey Chiropractic & Acupuncture/Patient Information
Dr. Douglas Halsey D.C.

Date: ____________________ SSN #: ____________________________________

Name: ___________________________________ Home/Cell Phone: ___________________________

Address: _______________________________ City: ______________ State: _____ Zip: __________

E-mail: ____

Age: __________ Birth Date: ________________________ Marital Status: M S W D

Occupation: ________________________ Employer: ____

Spouse: ____

How were you referred to our office? ____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint/Purpose of this appointment: ____

Date symptoms appeared or accident happened: ____

Is this due to: Auto _____ Work _____ Other ____

Have you ever had the same or similar condition? Yes _____ No _____

Date of last physical examination: ____

Do you have a history of stroke or hypertension? ____

Have you had any major illnesses, injuries, falls, auto accidents? ________________________________
____

Have you had any spinal surgeries? ____

Have you been treated for any major health condition by a physician in the last year? Yes ____ No ____
If yes, describe: ____

What medications or drugs are you taking? ____

Women: Are you pregnant? Yes _____ No _____

Name of Primary Insurance Company: ____

Name of Secondary Insurance Company (if any): ____

Patient's Signature: ____ Date: ________________

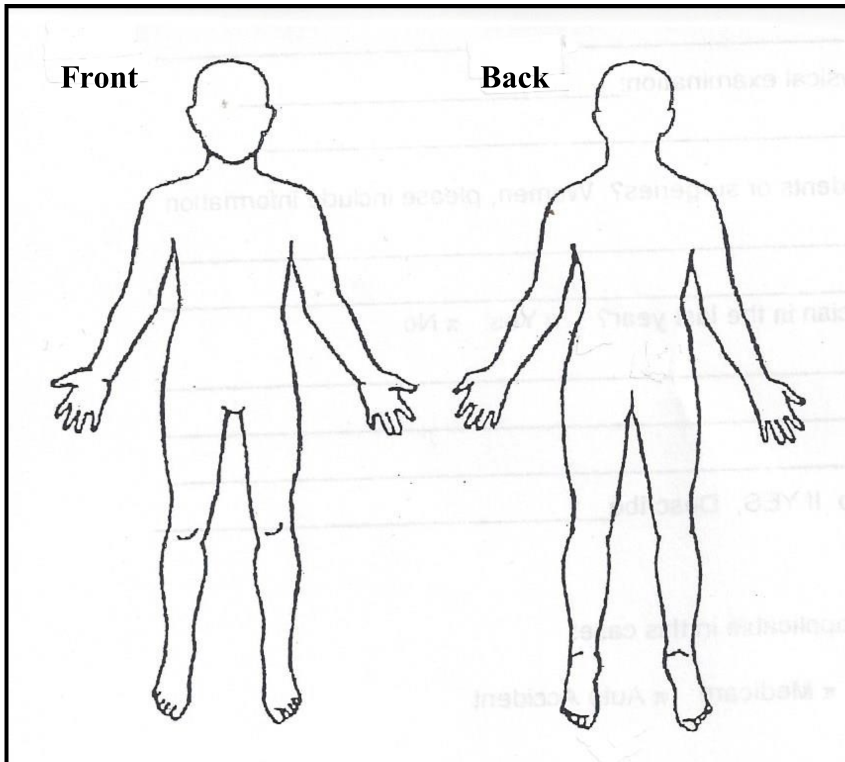
Parent/Guardian's Signature (if minor): ______________________________ Date: ________________

PATIENT NAME____ DATE__________________

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **NOW** or **P** if you have had these conditions **PREVIOUSLY**.

N=NOW P=PREVIOUSLY

Headaches	___________	Indigestion Problems	___________
Stiff Neck	___________	Loss of Balance	___________
Sleeping Problems	___________	Diabetes	___________
Back Pain	___________	Seizures/Epilepsy	___________
Muscle Spasms	___________	Pacemaker	___________
Dizziness	___________	Osteoporosis	___________
Shoulder/Neck/Arm Pain	___________	Broken Bones	___________
Numbness	___________	Rheumatoid Arthritis	___________
High Blood Pressure	___________	Cancer	___________
Weakness in Extremities	___________		



Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

A=Ache
B=Burning
ST=Stabbing
SP=Spasm
N=Numbness

Cervical______________________
____
____

Thoracic______________________
____
____

Lumbar_______________________
____
____

Extremities____________________
____
____

PAIN SCALE: Please circle the number that best describes your overall pain:

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE EXCRUCIATING

Patient Signature: ____

Parent/Guardian Signature (if a minor): ____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The Nature of the Chiropractic Adjustment
The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment
As a part of the analysis, examination, and treatment, you are consenting to the following procedures if necessary:

- ☑ Spinal Manipulation
- ☑ Palpation
- ☑ Vital Signs
- ☑ Range of Motion Testing
- ☑ Orthopedic Testing
- ☑ Basic Neurological Test
- ☑ Muscle Strength Test
- ☑ Postural Analysis Test
- ☑ Ultrasound
- ☑ Hot/Cold Therapy
- ☑ EMS
- ☑ Radiographic Studies
- ☑ SEMG
- ☑ Myofascial Release

The Material Risks Inherent in Chiropractic Adjustment
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The Probability of Those Risks Occurring
Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and Nature of Other Treatment Options
Other treatment options for your condition may include:
*Self-administered, over-the-counter analgesics and rest *Hospitalization *Surgery
*Medical care and prescription drugs, such as anti-inflammatory, muscle relaxants, and pain-killers
If you chose to use one of the above noted "other treatments" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read __ or have had read to me __ the above explanatin of the chiropractic adjustment and related treatment. I have discussed it with [Dr. Douglas Halsey] and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I herby give my consent to that treatment.

______________________________ ______________
Printed Name Date

____
Patient Signature

____
Signature of Parent or Guardian (if a minor)

Informed Consent to Initiate Acupuncture Treatment
HALSEY CHIROPRACTIC & ACUPUNCTURE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me by Dr. Douglas Halsey.

I have been informed that acupuncture is a generally safe method of treatment but that it may have some side effects including mild pain, bruising, numbness or tingling near the needling sites that may last a few days. Unusual risks include nerve damage and infection, although the clinic uses sterile disposable needles and maintains a clean and safe environment. While generally safe for pregnancy, some acupuncture points are contraindicated so if you are pregnant, please tell me when I take your clinical history.

I understand that the clinical and administrative staff may review my patient records but all my records will be kept confidential and will not be released without my written consent. I intend this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment in this office.

____ ________________
Printed Name Date

____
Patient Signature

____
Signature of Parent or Guardian (if a minor)